ARC 4779C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to managed care passive enrollment

The Human Services Department hereby amends Chapter 86, "Healthy and Well Kids in Iowa (HAWK-I) Program," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 514I.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapter 514I.

Purpose and Summary

These amendments add language to reflect the Department's implementation of a passive managed care enrollment process. HAWK-I-eligible individuals will be passively enrolled with a managed care plan; however, the eligibility effective date will remain consistent with current practices. The amendments also add necessary definitions, revise the time frame for a decision on eligibility, clarify policy on when a waiting period does not apply, revise premium payment language, eliminate the lock-out period for premium nonpayment, make technical changes, and remove outdated program language.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on August 28, 2019, as **ARC 4627C**.

The Department received one comment from the Iowa Hospital Association (IHA). IHA stated it is in favor of any proposal that seeks to increase efficiencies in the Medicaid program while ensuring the goals of improving patient outcomes and reducing the overall cost of care. However, hospitals have concerns with the implementation of a passive managed care enrollment process for HAWK-I-eligible individuals, based on past experience. IHA urged the Department to include safeguards to ensure the MCOs are aware of which members are assigned to them as soon as that assignment has been made. This will allow for eligible individuals to receive the care they need in a timely manner, and for providers to receive proper reimbursement. IHA does not disagree with the expansion of the premium payment grace period from 10 to 45 days. However, IHA urged the Department to implement a real-time process to ensure an individual has medical coverage. Hospitals want to avoid situations in which the MCO's system automatically removes or suspends the member from the MCO list for nonpayment if the premium payment is made after the due date but within the 45-day grace period. IHA is concerned that early removal could lead to delayed care and/or increased administrative burdens on providers.

No changes were made as a result of the concerns expressed by IHA. The Department will be monitoring any implementation issues and will address any potential problems as they occur. No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the HAWK-I Board on October 21, 2019.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on December 25, 2019.

The following rule-making actions are adopted:

ITEM 1. Adopt the following **new** definitions of "Enrollment broker" and "Passive enrollment process" in rule **441—86.1(514I)**:

"Enrollment broker" shall mean the entity the department uses to enroll eligible children with a managed care organization. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law.

"Passive enrollment process" shall mean the process by which the department assigns a child to a participating health or dental plan and which seeks to preserve existing provider-enrollee relationships, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available health or dental plans.

ITEM 2. Amend subrule 86.3(8) as follows:

86.3(8) *Time limit for decision.* Decisions regarding the applicant's eligibility to participate in the HAWK-I program shall be made within ~~ten~~ 45 working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed for reasons beyond the control of the department ~~or third-party administrator~~. Day one of the ~~ten-day~~ 45-day period starts the first working day following the date of receipt of a completed application and all necessary information and verification.

ITEM 3. Amend subrule 86.5(1) as follows:

86.5(1) *Initial application.* Coverage for a child who is determined eligible for the HAWK-I program on the basis of an initial application for either HAWK-I or Medicaid shall be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed. However, when the child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost. Also, a one-month waiting period shall be imposed for a child who is subject to a monthly premium pursuant to paragraph 86.8(2)*"c"* when the child's health insurance coverage ended in the month of application. EXCEPTIONS: A waiting period shall not be imposed if any of the following conditions apply:

a. to *e.* No change.

f. The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a qualified health plan through the Health Insurance Marketplace because the employer-sponsored insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).

g. The cost of family coverage that includes the child exceeds 9.5 percent of the annual household income.

ITEM 4. Amend rule 441—86.6(514I) as follows:

441—86.6(514I) Selection of a plan. ~~At the time of initial application, if there is more than one participating health or dental plan available in the child's county of residence, the applicant shall select the health or dental plan in which the applicant wishes to enroll as part of the eligibility process.~~ Upon the child's eligibility effective date, the child shall be assigned to a health or dental plan using the department's passive enrollment process. The enrollee may change plans only at the time of the annual review unless the provisions of ~~subrule 86.7(1) or~~ paragraph ~~86.6(2)"a"~~ 86.6(1)*"a"* or subrule 86.6(2) apply. ~~The applicant may designate the plan choice verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose but is not required.~~

86.6(1) *Period of enrollment.* Once enrolled in a health or dental plan, the child shall remain enrolled in the ~~selected~~ health or dental plan for a period of 12 months.

a. Exceptions. A child may be enrolled in a plan for less than 12 months if:

(1) The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the health or dental plan from which the child was originally disenrolled ~~unless the provisions of subrule 86.7(1) apply~~.

(2) No change.

(3) A request to change plans is accepted in accordance with ~~paragraphs 86.6(2)"b" and "c."~~ paragraph 86.6(1)*"b."*

b. Request to change plan. An enrollee may ask to change the health or dental plan either verbally or in writing to the enrollment broker:

(1) Within 90 days following the date ~~the initial enrollment was sent to the health or dental plan regardless of the reason for the plan change or whether the original health or dental plan was selected by the applicant or was assigned in accordance with subrule 86.6(3)~~ of the enrollee's initial enrollment with the health or dental plan for any reason.

(2) At any time for cause. "Cause" as defined in 42 CFR 438.56(d)(2) as amended to ~~May 13, 2010~~ May 6, 2016, includes, but is not limited to:

1. to 4. No change.

All approved changes shall be made prospectively and shall be effective no later than the first day of the second month beginning after the date on which the change request is received.

~~*c. Response to request.*~~

~~(1) If the enrollee has not requested to change health or dental plans within 90 days following the date the initial enrollment was sent to the health or dental plan and it is determined that cause does not exist, the request to change plans shall be denied.~~

~~(2) All approved changes shall be made prospectively and shall be effective on the first day of the month following the month in which the request was made.~~

86.6(2) ~~*Failure to select a health or dental plan.* When more than one health or dental plan is available, if the applicant fails to select a health or dental plan within ten working days of the written request to make a selection, the third-party administrator shall select the health or dental plan and notify the family of the enrollment. The third-party administrator shall select the plan on a rotating basis to ensure an equitable distribution between participating health and dental plans.~~

~~**86.6(3)**~~ **86.6(2)** *Child moves from the service area.* The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating health or dental plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

~~**86.6(4)**~~ **86.6(3)** *Change at annual review.* If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing to the enrollment broker. ~~Form 470-3574, Selection of Plan, may be used for this purpose.~~ The child

shall remain enrolled in the current health or dental plan if the family does not notify the ~~third-party administrator~~ enrollment broker of a new health or dental plan choice by the end of the current 12-month enrollment period.

ITEM 5. Amend subrule 86.7(3) as follows:

86.7(3) *Nonpayment of premiums.* The child shall be canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3)~~, 86.8(4)~~ and 86.8(5), unless premiums are subsequently received in accordance with the grace period provisions of subrule 86.8(4).

ITEM 6. Amend rule 441—86.8(514I) as follows:

441—86.8(514I) Premiums and copayments.

86.8(1) and **86.8(2)** No change.

86.8(3) *Due date.*

a. No change.

b. Payment upon renewal. "Renewal" means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

(1) No change.

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the ~~third-party administrator~~ department shall notify the health and dental plans of the enrollment.

c. Subsequent payments. All subsequent premiums are due by the fifth day of each month for the next month's coverage ~~and must be postmarked no later than the last day of the month before the month of coverage~~. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. No change.

86.8(4) *Grace period.* A grace period shall be allowed on any monthly premium not received as prescribed in paragraph 86.8(3)*"c."* The grace period shall be the ~~coverage month for which the premium is due~~ month immediately following the last month for which the premium has been paid.

a. Failure to submit a premium by the last calendar day of the grace period shall result in disenrollment.

b. If the premium for the grace period and the premium for the following month's coverage is subsequently received within 45 calendar days following the last calendar day of the grace period, coverage will be reinstated ~~if the premium was postmarked or otherwise paid:~~, effective the first day of the calendar month following the grace period, without the need to reapply for coverage.

~~(1) In the grace period, or~~

~~(2) In the 14 calendar days following the grace period.~~

86.8(5) *Method of premium payment.* Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the ~~third-party administrator~~ department.

86.8(6) and **86.8(7)** No change.

~~**86.8(8)** *Program lock-out.* A child who has been disenrolled from the program due to nonpayment of premiums shall be locked out of the program until the arrearage is paid in full or for a period not to exceed 90 days, whichever occurs first.~~

~~*a.* Failure to pay the unpaid premiums shall result in denial of the application if less than 90 days has elapsed since the effective date of disenrollment. EXCEPTION: The unpaid premium obligation shall be reduced to zero if upon reapplication a premium would not be assessed because the household's income is less than 150 percent of the federal poverty level.~~

~~*b.* If the arrearage is not paid within 24 months of failing to pay a premium, the debt shall be expunged and shall no longer be owed.~~

ITEM 7. Amend subrule 86.20(3) as follows:

86.20(3) *Premiums.* Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families who meet the provisions of subparagraph 86.8(2)*"a"*(1) or to families whose countable income is less than or equal to 167 percent of the federal poverty level for a family of the same size using the modified adjusted gross income methodology.

b. If the family's countable income is equal to or exceeds ~~167~~ 168 percent of the federal poverty level but does not exceed 203 percent of the federal poverty level for a family of the same size, the premium is $5 per child per month with a $10 monthly maximum per family.

c. to *e.* No change.

f. The provisions of subrules 86.8(3) to 86.8(6) ~~and 86.8(8)~~ apply to premiums specified in this subrule.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/20/19.